KAPLAN BARRON PEDIATRICS

4117 Browns Lane

Louisville, Ky 40220

502-452-6337 Fax 502-458-5327

REQUEST FOR MEDICAL RECORDS

Today's date_____

Previous Physician _____

Address_____

City_____ State_____ Zip_____

Phone_____ Fax_____

Patient(s) covered by this request.

Full Name _____DOB_____

Full Name _____DOB_____

Full Name _____DOB_____

Full Name_____ DOB_____

Parent / Guardian information

Name_____

Address_____ Phone _____

As the undersigned and legal guardian of the above-named patient(s), I hereby authorize the release of medical records to Kaplan Barron Pediatrics. I understand that this information may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to revoke this authorization in writing at any time. This request is valid for one year from the date of my own signature.

Signature_____ Date_____

Relationship to patient_____

IF MORE THAN 25 PAGES PLEASE MAIL, DO NOT FAX